

MDR Tracking Number: M5-04-0351-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on September 23, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the outpatient office visits, Functional Capacity Evaluation, work hardening/work conditioning, and Psychiatric diagnostic interview were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatments listed above were not found to be medically necessary, reimbursement for dates of service from 02/10/03 to 07/02/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 5th day of January 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

December 31, 2003

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: MDR #: M5-04-0351-01
IRO Certificate No.: IRO 5055

REVISED DECISION
Revised Disputed Services

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

Clinical History:

The patient is a 50-year-old male who injured his left elbow on-the-job on _____. This resulted in pains and swelling in that elbow, associated with loss of feeling in the medial fingers of his left hand. MRI of the left forearm on 02/15/02 revealed mild to moderate hypertrophic changes at the wrist joints.

Additionally, the record shows that the patient had surgery on the left elbow on 03/18/03.

Disputed Services:

Outpatient office visits, Functional Capacity Evaluation, work hardening/work conditioning and Psychiatric diagnostic interview during the period 02/10/03 through 07/02/03.

Decision:

The reviewer agrees with the determination of the insurance carrier. The services in question are not medically necessary.

Rationale:

Based on the documentation provided, there is inadequate objective medical evidence to establish medical necessity of the services in question. The patient was determined to have reached Maximum Medical improvement on 09/25/02. The patient remained off duty for over a year after his injury and stated that his condition became worse with conservative efforts.

I am the Secretary and General Counsel of _____ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,